



2018 Quality Payment Program (QPP) Measure Specification and Measure Flow Guide for Registry Submission of Individual Measures

Utilized by Individual Eligible Clinicians for Registry Submissions or Clinical Practices Participating in Group Practice Reporting Option (GPRO) for Registry Submissions

12/11/2017

Introduction

This document contains general guidance for the 2018 Quality Payment Program (QPP) Individual Measure Specifications and Measure Flows for registry submissions. The individual measure specifications are detailed descriptions of the quality measures and are intended to be utilized by individual eligible clinicians reporting individual measures via Quality Clinical Data Registry (QCDR) or Qualified Registries and by group practices submitting via Qualified Registry for the 2018 QPP. In addition, each measure specification document includes a measure flow and associated algorithm as a resource for the application of logic for data completeness and performance. Please note that the measure flows were created by CMS and may or may not have been reviewed by the Measure Steward. These diagrams should not be used in place of the measure specification but may be used as an additional resource.

Submission Methods

Individual measure specifications for registry submissions may be utilized for Qualified Registry and Qualified Clinical Data Registries (QCDRs) data submission methods. Below outlines which measure specifications can be utilized for the other data submission methods.

- Measure specifications for individual measure reporting via claims are separate measure documents.
- Group practices electing to submit via the Web Interface should utilize the Web Interface Measure documents
- Measure specifications for electronic health record (EHR) based reporting should utilize the electronic clinical quality measures (eCOMs).
- Information regarding CG-CAHPS may be found at: [Accredited Care Organizations](#)
Please note that this link is directed to the Accredited Care Organization webpage.

Individual Measure Specifications

Each measure is assigned a unique number. Measure numbers for 2017 QPP represents a continuation in numbering from the 2016 Physician Quality Reporting System (PQRS) measures. Measure stewards have provided revisions for the 2016 PQRS measures that are continuing forward in the 2017 QPP.

Frequency with Definitions

Frequency labels are provided for each measure and included in each measures instruction as well as the measure flow. The analytical submitting frequency defines the time period or event in which the measure should be submitted. Each individual eligible clinician participating in 2018 QPP should submit during the performance period according to the frequency defined for the measure. Below are definitions of the analytical submitting frequencies that are utilized for calculations of the individual measures:

- **Patient-Intermediate** measures are submitted a minimum of once per patient during the performance period. The most recent quality-data code will be used, if the measure is submitted more than once.
- **Patient-Process** measures are submitted a minimum of once per patient during the performance period. The most advantageous quality-data code will be used if the measure is submitted more than once.
- **Patient-Periodic** measures are submitted a minimum of once per patient per timeframe specified by the measure during the performance period. The most advantageous quality-data code will be used if the measure is submitted more than once. If more than one quality-data code is submitted during the episode time period, performance rates shall be calculated by the most advantageous quality-data code.
- **Episode** measures are submitted once for each occurrence of a particular illness or condition during the performance period.
- **Procedure** measures are submitted each time a procedure is performed during the performance period.
- **Visit** measures are submitted each time a patient is seen by the individual eligible clinician during the performance period.

Performance Period

Performance period for the measure may refer to the overall period of January 1st to December 31st. Although, there may be measures where the clinical action of the measure may have a different timeframe to determine if the quality action indicated within the measure was performed to meet performance. There are several sections (Instruction, Description, or Numerator Statement) within the measure specification that could include information on the performance period. For example, in Quality ID # 12 (NQF 0086): Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation the submitting eligible clinician would be allowed to 'look back' from the date of the denominator eligible encounter and 'forward' to the end of the current program year to confirm the most advantageous numerator option met.

Denominator and Numerator

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. The denominator is the lower part of a fraction used to calculate a rate, proportion, or ratio. The numerator is the upper portion of a fraction used to calculate a rate, proportion, or ratio. Also called the measure focus, it is the target process, condition, event, or outcome. Numerator criteria are the processes or outcomes expected for each patient, procedure, or other unit of measurement defined in the denominator.

Denominator Codes (Eligible Cases)

The denominator population may be defined by demographic information, certain International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis, Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted **by individual eligible clinicians and group practices** to a registry for data submission. Registry data submission may include patients from all payers not just Medicare Part B Physician Fee Schedule (PFS) covered services.

If the specified denominator codes for a measure are not applicable to the patient (for the same date of service) as submitted by the individual eligible clinician or group practice, then the patient does not fall into the denominator population, and the measure does not apply to the patient. Some measure specifications are adapted as needed for implementation in agreement with the measure steward.

Measure specifications include specific instructions regarding CPT Category I modifiers, place of service codes, and other detailed information. Each **eligible clinician and group practice** should carefully review the measure's denominator coding to determine whether codes submitted to a registry meet denominator inclusion criteria.

Denominator exclusions describe a circumstance where the patient should be removed from the denominator. Measure specifications define denominator exclusion(s) in which a patient should not be included in the intended population for the measure even if other denominator criteria is applicable. Quality-data codes or equivalent codes are available to describe the denominator exclusion and are provided within the measure specification. Patients that meet the intent of the denominator exclusion do not need to be included for data completeness or in the performance denominator of the measure.

Numerator Quality-Data Codes

If the patient does fall into the denominator population and no denominator exclusions apply, the applicable Quality Data Codes (QDCs) or equivalent as indicated by the registry that define the numerator options should be submitted for data completeness of quality data for a measure for registry-based submissions.

If the intended clinical action for the measure is performed for the patient, quality-data code(s) or equivalent from the registry are available to describe that performance has been met and should be submitted to the registry.

Denominator Exception

When a patient falls into the denominator, but the measure specifications define circumstances in which a patient may be appropriately deemed as a denominator exception. CPT Category II code modifiers such as 1P, 2P and 3P quality-data codes, or equivalents referenced from the registry are available to describe medical, patient or system reasons for denominator exceptions and can be submitted to the registry. A denominator exception would remove a patient from the performance denominator only if the numerator criteria are not met. This allows for the exercise of clinical judgement by the eligible clinician.

Performance Not Met

When the denominator exception does not apply, a measure-specific CPT Category II reporting modifier 8P, quality-data code, or equivalent from the registry may be used to indicate that the quality action was not provided for a reason not otherwise specified and should be submitted to the registry.

Inverse Measure

A lower calculated performance rate for this type of measure would indicate better clinical care or control. The "Performance Not Met" numerator option for an inverse measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

Each measure specification provides detailed Numerator Options for submitting on the quality action described by the measure. Although a registry may or may not utilize these same QDCs, the numerator clinical concepts described for each measure are to be followed when submitting to a registry.

HCPCS coding may include G-codes, D-codes, or S-codes. These HCPCS codes may be found in the denominator and would be associated with billable charges. QDC's may be found in the denominator or numerator and may utilize HCPCS coding. These QDC's describe clinical outcomes or quality actions that assist with determining the intended population or numerator outcome.

Individual Measure Submission

For eligible clinicians reporting individually, measures (including patient-level measure[s]) may be submitted for the same patient by multiple eligible clinicians practicing under the same Tax Identification Number (TIN). If a patient sees multiple providers during the performance period, that patient can be counted for each individual NPI reporting if the patient meets denominator inclusion. The following is an example of two provider NPIs (National Provider Identifiers), billing under the same TIN who are intending to submit Quality ID #6: Coronary Artery Disease (CAD): Antiplatelet Therapy. Provider A sees a patient on February 2, 2018 and prescribes an aspirin and submits the appropriate quality-data code (QDC) for Quality ID #6. Provider B sees the same patient at an encounter on July 16, 2018 and verifies that the patient has been prescribed and is currently taking an aspirin. Provider B should also submit the appropriate QDC's for the patient at the July encounter to meet data completeness for submission of Quality ID #6.

Group Practice Reporting Option Submission

Eligible clinician submitting under a group practice selecting to participate in the group practice reporting option (GPRO) under the same Tax Identification Number (TIN), should be submitting on the same patient, when instructed within the chosen measure. For example, if submitting Quality ID #130: Documentation of Current Medications in the Medical Record all eligible clinician under the same TIN would report each denominator eligible instance as instructed by this measure.

If the group practice chooses a measure that is required to be submitted once per performance period, then this measure should be submitted at least once during the measure period by at least one eligible clinician under the TIN. Quality ID #6: Coronary Artery Disease (CAD): Antiplatelet Therapy is an example of a measure that would be submitted once per performance period under the TIN.

CMS recommends review of any measures that an individual eligible clinician or group practice intend to submit. Below is an example measure specification that will assist with data completeness for a measure. For additional assistance, please contact the Service Now help desk at **1-866-288-8292** (Monday – Friday 8:00AM – 8:00PM Eastern Time) or email via QPP@cms.hhs.gov.

Measure Specification Format (Refer to the Example Measure Specification Below)

Measure number, NQF number (if applicable), Measure title and domain

Submission method option

Measure type

Measure description

Instructions on reporting including frequency, timeframes, and applicability

Denominator statement, denominator criteria, coding, and denominator exclusion

Numerator statement and coding options (performance Met, denominator exception, performance not met)

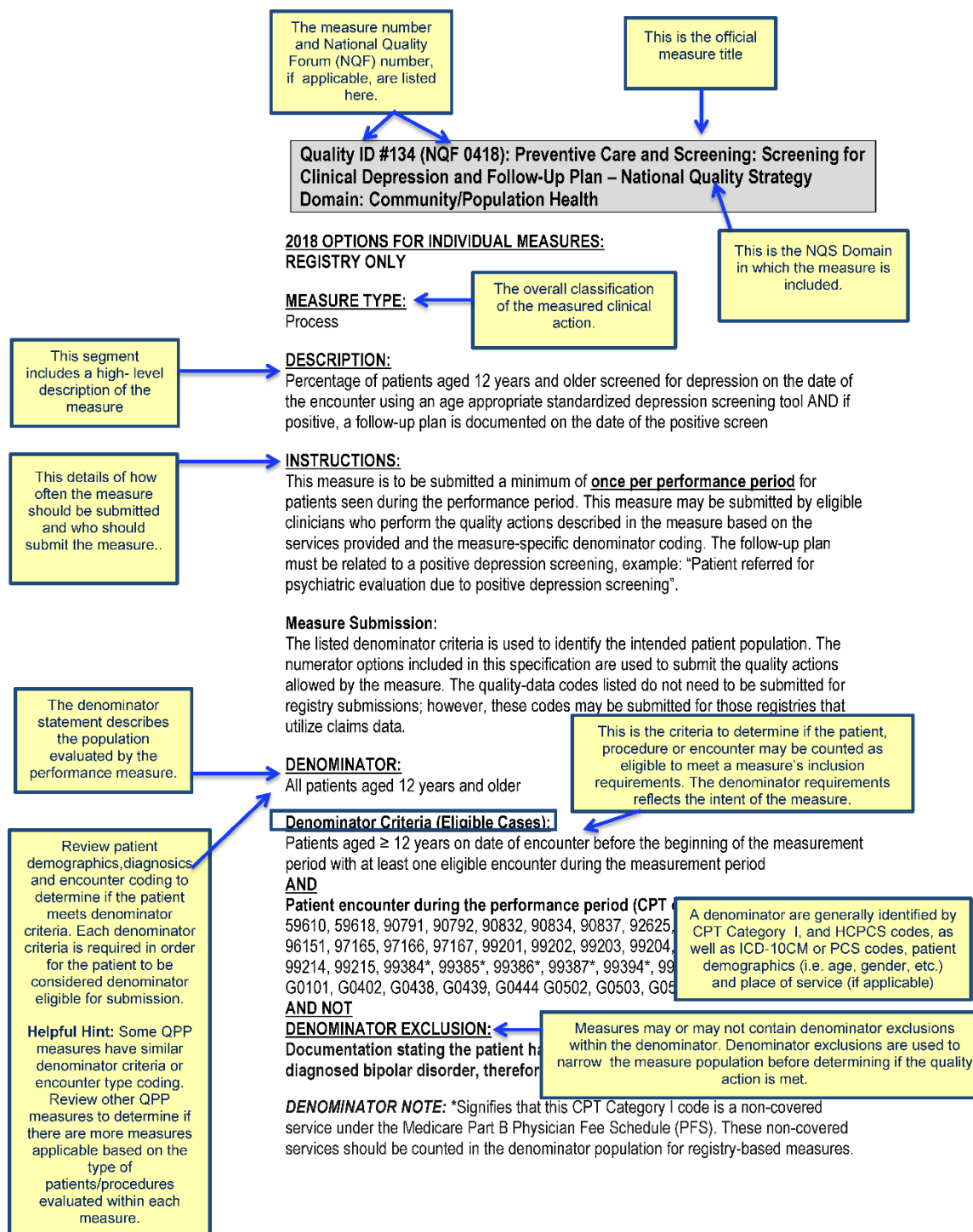
Definition(s) of terms where applicable

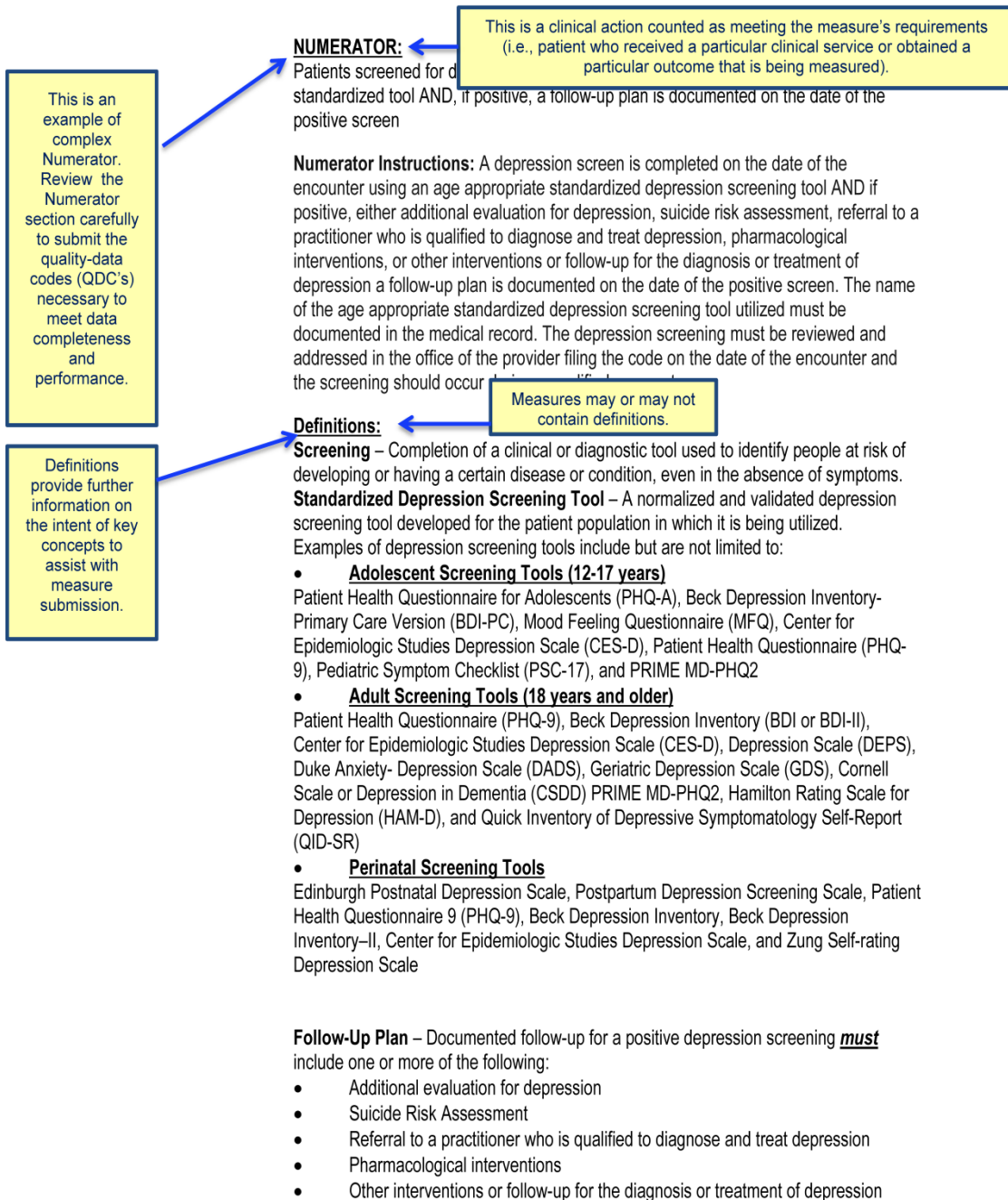
Rationale

Clinical recommendations statement or clinical evidence supporting the measure intent

The Rationale and Clinical Recommendation Statements sections provide limited supporting information regarding the quality actions described in the measure. Please contact the measure steward for section references and further information regarding the clinical rationale and recommendations for the described quality action. Measure steward contact information is located on the last page of the Measures List document, which can be accessed at: <https://qpp.cms.gov/measures/quality>.

Example Individual Registry Measure Specification:





* Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

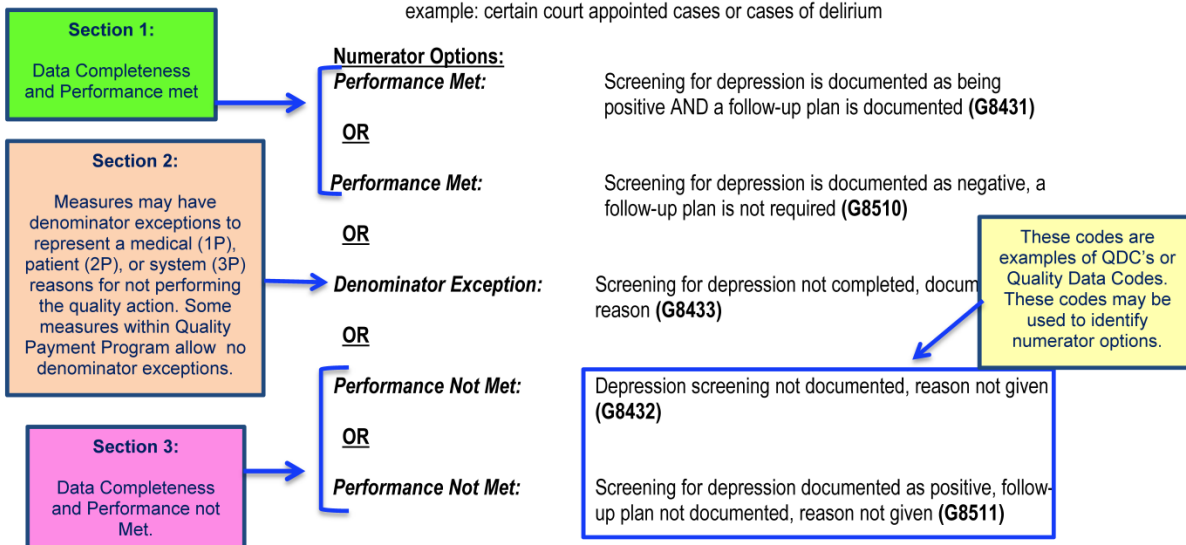
Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion)

- Patient has an active diagnosis of depression - F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
- Patient has a diagnosed bipolar disorder - F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, , F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) –

One or more of the following conditions are documented:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium



RATIONALE:

2014 U.S. survey data indicate that 2.8 million (11.4 percent) adolescents aged 12 to 17

This is a brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.

Behavioral Health Statistics and Quality, 2015). The World Health Organization (WHO), as cited by Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Data indicate that approximately 80% of people diagnosed with depression report some level of difficulty in functioning because of their depressive symptoms. For example, 35% of males and 22% of females with depression reported that their depressive symptoms make it extremely difficult for them to work, get things done at home, or get along with other people. Additionally, more than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their depressive symptoms (Pratt & Brody, 2008). In young adulthood, major depressive disorder (MDD) has been found to be associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning (Williams et al., 2009, p. e716). In the perinatal period, depression and other mood disorders, such as bipolar disorder and anxiety disorders, can have devastating effects on women, infants, and families. Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (American College of Obstetricians and Gynecologists, 2015).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, 2010, p. 948). "Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner, 2010, p. 948). "In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" (Sui, A. and USPSTF, 2016). Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs. "In the United States, an estimated \$22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated \$23 billion in 2011" (Sui, A. and USPSTF, 2016).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

This is a summary of the clinical recommendations based on best practices.

Adolescent Recommendation (12-18 years)

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 360).

"Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up" (ICSI, 2013, p.16).

Adult Recommendation (18 years and older)

"The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."
2. "Clinicians should establish and maintain follow-up with patients."
3. "Clinicians should screen and monitor depression in pregnant and post-partum women." (Trangle, 2016 p.p. 9 – 10)

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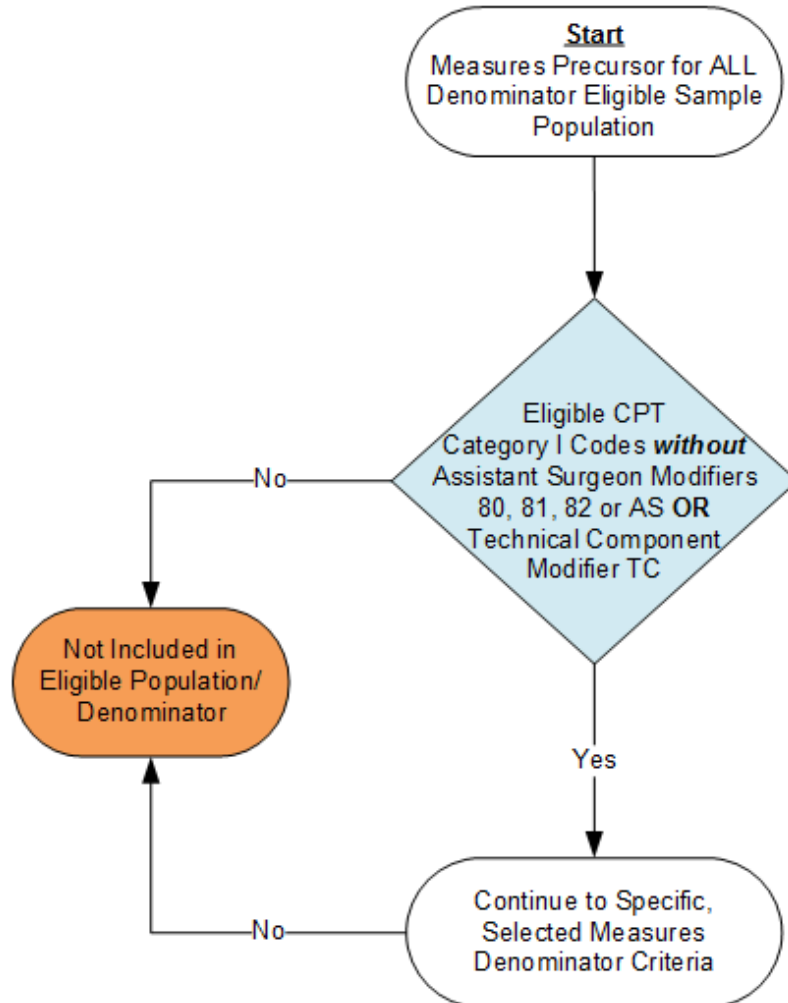
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Interpretation of Individual Registry Measure Flows

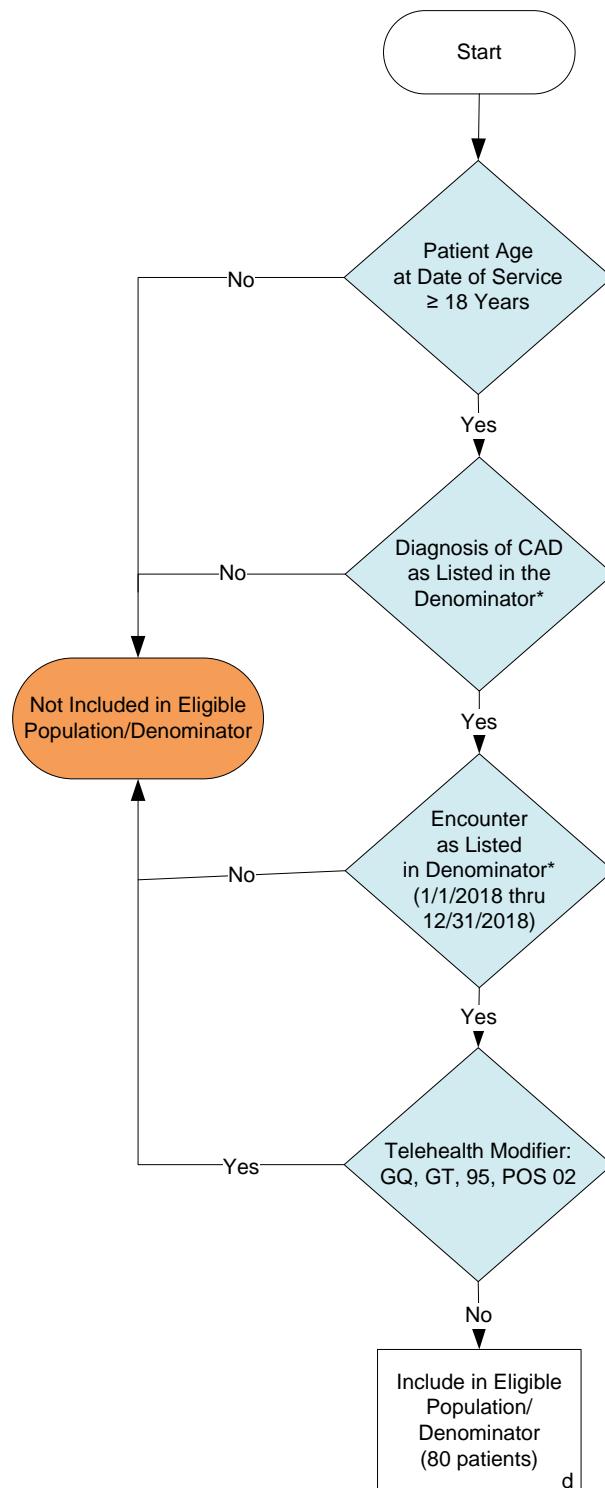
Denominator

The Individual Measure Flows are designed to provide interpretation of the measure logic and calculation methodology for data completeness and performance rates. The flows start with the identification of the patient population (denominator) for the applicable measure's quality action (numerator). When determining the denominator for all measures, please remember to include patients from all payers and CPT I Categories **without** modifiers 80, 81, 82, AS or TC.

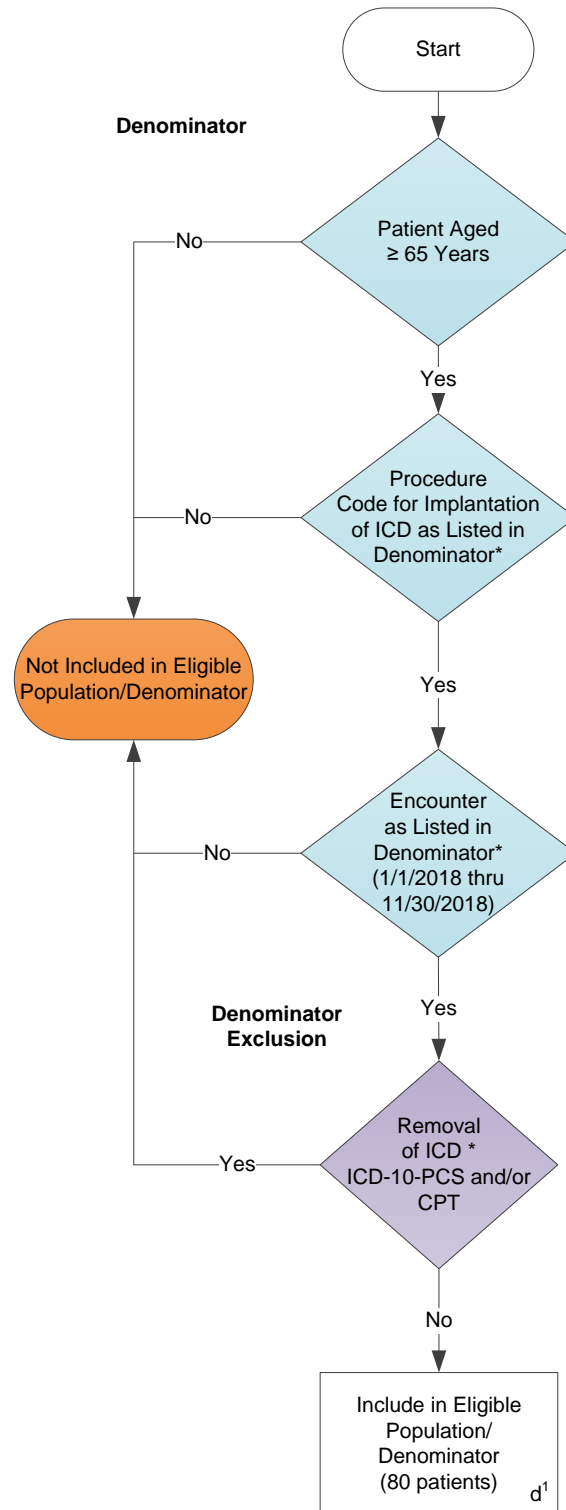
Below is an illustration of additional prerequisite denominator criteria to obtain the patient sample for all 2018 Individual Measures:



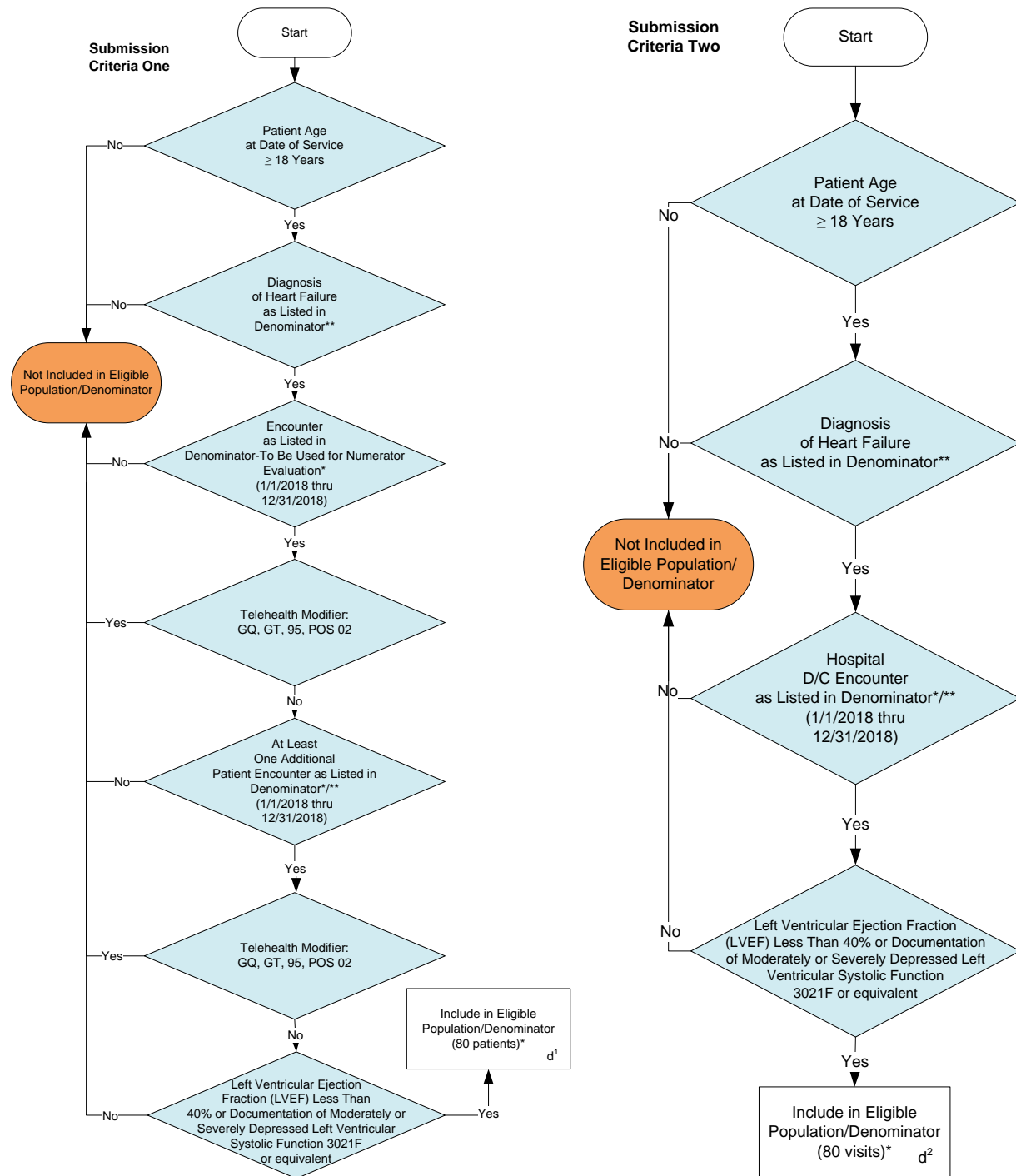
The Individual Measure Flows continue with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter "d" by the patient population that meets the measures inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for Quality ID #6 NQF # 0067: Coronary Artery Disease (CAD): Antiplatelet Therapy:



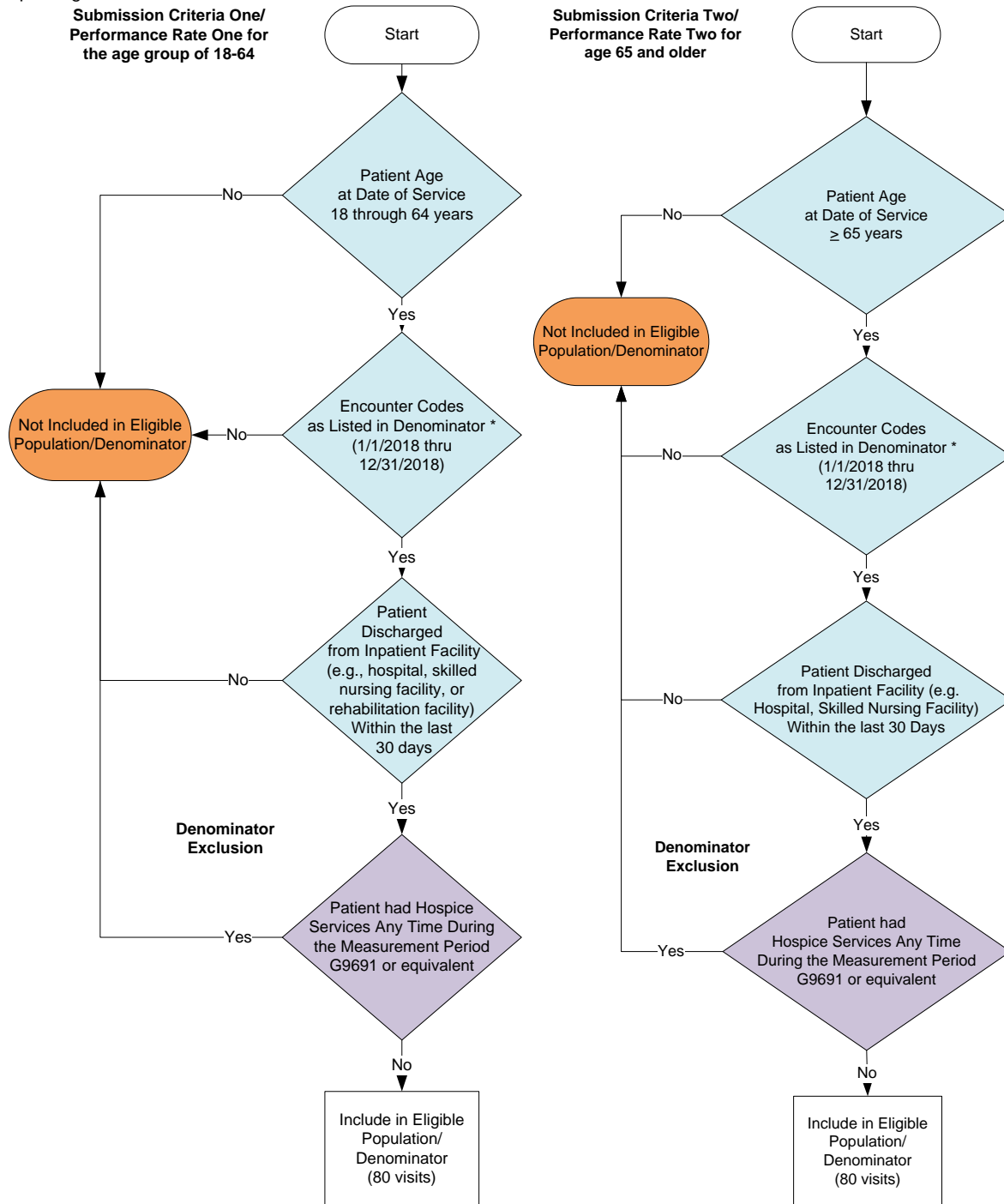
In some instances denominator exclusions will be found within the denominator. Quality ID #348: HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate below is an example of a measure that exhibits a denominator exclusion that is labeled and is represented by a purple diamond.



Some measures, such as Quality ID #5 Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD), have multiple options to determine the measure's denominator. Patients meeting the reporting criteria for either denominator option are included as part of the eligible population. Review the measures specification to determine if multiple performance rates are required for each reporting criteria.

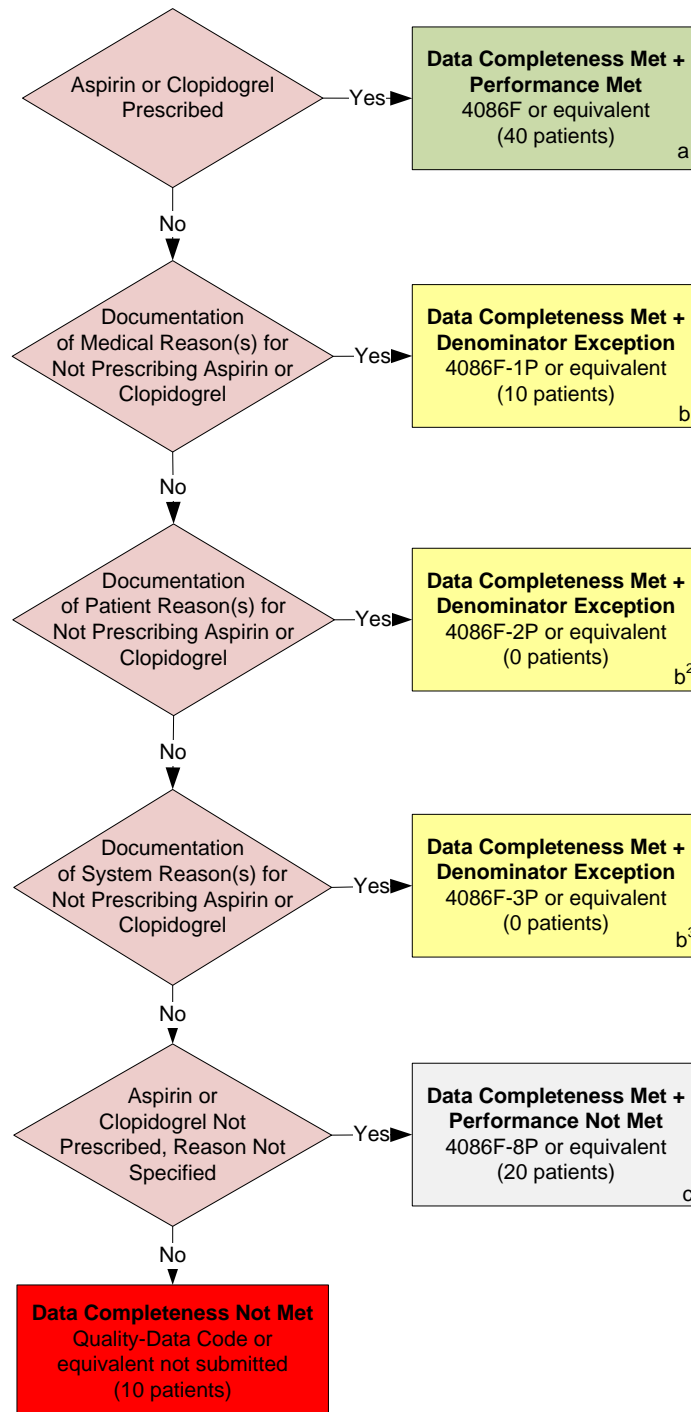


Some measures, such as Quality ID #46 Medication Reconciliation Post-Discharge have multiple submission criteria and multiple performance rates. Patients meeting the criteria for either denominator option are included as part of the eligible population. Review the measures specification to determine if multiple performance rates are required for each reporting criteria



Numerator

Once the denominator is identified, the flow illustrates and stratifies the quality action (numerator) for data completeness. Depending on the measure, there are several outcomes that may be applicable for submitting the measures outcome: Performance Met = "a"/green, Denominator Exception = "b"/yellow, Performance Not Met = "c"/gray, and Data Completeness Not Met = red box. On the flow, these outcomes are color-coded and labeled to identify the particular outcome of the measure represented. This is illustrated below for Quality ID #6 NQF # 0067: Coronary Artery Disease (CAD): Antiplatelet Therapy:



Denominator/Numerator Variation of Claims-Based vs. Registry-Based Reporting

For measures reportable via claims and registry, there are separate Individual Measure Specifications and Flows. The denominator for the registry-based individual measure may differ slightly from the denominator as outlined in the claims-based individual measure specification. Some measures, such as Quality ID #19, have a clarifying code and/or language (e.g. G-code G8397 for Quality ID #19) in the numerator to identify eligible patients when no CPT I or ICD-10 diagnosis code exists. In the case of Quality ID #19, an applicable CPT I code does not exist for dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy. In claims-based reporting, an eligible clinician would report the numerator code G8397 to identify patients who had a dilated macular or fundus exam with documentation of the results. To comply with the measure steward's intent of the measures and since registries may not necessarily be reliant on claims data; the measure specification and flow shows these quality-data codes or clinical concepts in the denominator. Therefore the numerator quality-data code options for registry-based measure specifications and flow may vary from the claims-based measure specification and flow.

Algorithms

Data Completeness Algorithm

The Data Completeness Algorithm is based on the eligible population and sample outcomes of the possible quality actions as described in the flow of the measure. The Data Completeness Algorithm provides the calculation logic for patients who have been submitted in the eligible clinicians' appropriate denominator. Data completeness for a measure may include the following categories provided in the numerator: Performance Met, Denominator Exception, and Performance Not Met. Below is a sample data completeness algorithm for Quality ID #6. In the example, 80 patients met the denominator criteria for eligibility, where 40 patients had the quality action performed (Performance Met), 10 patients did not receive the quality action for a documented reason (Denominator Exception), and 20 patients were reported as not receiving the quality action (Performance Not Met). **Note:** In the example, 10 patients were eligible for the measure but were not reported (Data Completeness Not Met). Additionally, depending on the registries data source and abstraction method, the data completeness may not reflect missing numerator data.

Data Completeness =

$$\frac{\text{Performance Met (a=40 pts)} + \text{Denominator Exception (b1+b2+b3=10 pts)} + \text{Performance Not Met (c=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Algorithm

The Performance Algorithm calculation is based on only those patients where data completeness was met for the measure. For those patients reported, the numerator is determined by completing the quality action as indicated by Performance Met. Meeting the quality action for a patient, as indicated in the Registry Individual Measure Specification, would add one patient to the denominator and one to the numerator. Patients reporting with Denominator Exceptions are subtracted from the performance denominator when calculating the performance rate percentage. Below is a sample performance rate algorithm that represents this calculation for Quality ID #6. In this scenario, the patient sample equals 70 patients where 40 of these patients had the quality action performed (Performance Met) and 10 patients were reported as having a Denominator Exception.

Performance Rate=

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients) - Denominator Exception (b1+b2+b3=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

For measures with inverse performance rates, such as Quality ID #1 (NQF 0059) Diabetes: Hemoglobin A1c Poor Control, a lower rate indicates better performance. Submitting the Performance Not Met is actually the clinically recommended outcome or quality action.

Multiple Performance Rates

QPP measures may contain multiple performance rates. The Instructions section of the individual measure will provide guidance if the measure is indeed a multiple performance. The Individual Measure Flow for these measures

includes algorithm examples to understand the different data completeness and performance rates required for the measure. Please note, only the performance rates outlined in the measure specification are to be submitted for registry submissions. CMS, with measure steward feedback, will calculate an overall performance rate for the measure if none is specified within the measure.